MDS 3.0 Question and Answers
October 15, 2010

MDS Coordinators are encouraged to review the following questions and answers as they are the most recent answers received from CMS or obtained from other resources, i.e. RAI User's Manual Version 3.0, CMS transition guidances.

1. Section A: Identification Information. For the first MDS 3.0 Assessment how are: **A310E. Is this Assessment the first Assessment (OBRA, PPS, or Discharge) since the Most Recent Admission?; A1600. Entry Date; and A1700. Type of Entry?**

   Answer: Due to the transition from the MDS 2.0 to 3.0, the first assessment is coded A310E. Code 1, yes. See the Transition Document MDS 2.0 to MDS 3.0 at http://www.cms.gov/NursingHomeQualityInits/downloads/MDS30TransitionFromMDS20.pdf A0310 Type of Assessment.
   However, coding for A1600 and A1700 should follow the instructions in the manual on A-18. If the resident has never been discharged from the facility since their initial admission, enter the date of their initial admission. If since their initial admission, the resident has left the facility – discharge return anticipated and returned to the facility within 30 days of discharge, use the date they reentered the facility . A1700. Code the event that corresponds with the date coded in A1600 - initial admission (1) or reentry (2).

2. Section C: Cognitive Patterns. **C0200-C0500 Brief Interview for Mental Status.** May the following techniques be used for conducting the BIMS?
   a. A resident can communicate only using "yes"/"no" responses. S/he may be able to recall the 3 items, but is unable to say the words or write them down. May the resident be shown several words and be given the opportunity to select "sock, blue, bed" from among them? For example, 3 clothing items, 3 colors, and 3 pieces of furniture may be listed and the resident asked to choose the items from the list by pointing to each word on the list.
   b. A resident communicates using a picture/message board. May the resident be shown a board that has 3 clothing items, 3 colors, and 3 pieces of furniture on it, and asked to choose the recall items by pointing to the correct items?

   Answer: Conducting the BIMS in the manner stated above is acceptable. The intent of the BIMS is to allow the resident to use their primary method of communication and for some residents this may be the use of an assistive device such as a communication board that has words or icons on them.

3. Section G: Functional Status. **G0110: Activities of Daily Living Assistance**. Are contracted rehabilitation staffs or rehabilitation staff employed by the facility considered facility staff? If yes, can their assistance be coded?

   Answer: Yes, these staffs are considered facility staff. The assistance they provide a resident with their ADLs may be coded if it is not provided in the rehabilitation room.

4. Section O: Special Treatments, Procedures, and Programs. **Item O0100E, tracheostomy care**.

   Is this coded if a resident does their own tracheostomy care?

   Answer: O-2 of the Manual states Code cleansing of the tracheostomy and/or cannula in this item. Recent information received from CMS has stated that it should not be coded if the resident is cleansing their own tracheostomy and/or cannula.

5. Section O: Special Treatments, Procedures, and Programs. **Item O0250: Influenza Vaccine**. Please clarify what is meant by this year's influenza season.

   Answer: Although there is not a specific date at this time on the CDC website, according to CDC the flu season begins when the vaccine is made available to the public. For MDS 3.0 purposes, CMS has stated facilities can consider the 2010 -2011 flu season to have begun October 1, 2010.

6. Section Q: Participation in Assessment and Goal Setting. If a family member is also the legal guardian, are both **Q0100B and Q0100C** Code 1, yes?

   Answer: Yes.

7. Section Q: Participation in Assessment and Goal Setting. **Q0600. Referral**. If the facility has a discharge plan in place for a resident, must the local contact agency be contacted?

   Answer: The facility must offer the resident the opportunity to meet with a representative from the local contact agency. The resident has the right to decline the offer. The clinical record should have supporting documentation of the discharge plan, facility's offer to the resident, and the resident's decision to decline the offer.